

NDMS CREDENTIALS VERIFICATION

CERTIFICATION OF CURRENT LICENSURE

I certify that, except as noted, the individual listed below has provided evidence of current licensure/certification/registration to practice under the laws of this State.

Team Name:

LAST NAME	FIRST NAME	MI	SSN	LICENSE NUMBER	STATE LIC. ISSUED	DATE LIC. EXPIRES	EMT SKILL LEVEL (if appropriate)

Signature of Team Official

Date

Team Title/Position

Type/Print Name

For each applicant, attach a single copy of this form and his/her license or certificate.